Declaration for Federal Employment

Form Approved
OMB No. 3206-0182

GENERAL INFORMATION

1. **FULL NAME** *(First, middle, last)* ◆	2. **SOCIAL SECURITY NUMBER** ◆
3. **PLACE OF BIRTH** *(Include city and state or country)* ◆	4. **DATE OF BIRTH** *(MM/DD/YYYY)* ◆
5. **OTHER NAMES EVER USED** *(For example, maiden name, nickname, etc)* ◆ ◆	6. **PHONE NUMBERS** *(Include area codes)* Day ◆ Night ◆

Selective Service Registration

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must register with the Selective Service System, unless you meet certain exemptions.

7a. Are you a male born after December 31, 1959? ☐ YES ☐ NO *If "NO" skip 7b and 7c. If "YES" go to 7b.*

7b. Have you registered with the Selective Service System? ☐ YES ☐ NO *If "NO" go to 7c.*

7c. If "NO," describe your reason(s) in item #16.

Military Service

8. Have you ever served in the United States military? ☐ YES *Provide information below* ☐ NO

If you answered "YES," list the branch, dates, and type of discharge for all active duty.

If your only active duty was training in the Reserves or National Guard, answer "NO."

Branch	From *MM/DD/YYYY*	To *MM/DD/YYYY*	Type of Discharge

Background Information

For all questions, provide all additional requested information under item 16 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 9,10, and 11, your answers should include convictions resulting from a plea of *nolo contendere* (no contest), but omit (1) traffic fines of $300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law, and (5) any conviction for which the record was expunged under Federal or state law.

		YES	NO
9.	During the last 10 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.*	☐	☐
10.	Have you been convicted by a military court-martial in the past 10 years? *(If no military service, answer "NO.") If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.*	☐	☐
11.	Are you now under charges for any violation of law? *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.*	☐	☐
12.	During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? *If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.*	☐	☐
13.	Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) *If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.*	☐	☐

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Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) *If "YES," use item 16 to provide the relative's name, relationship, and the department, agency, or branch of the Armed Forces for which your relative works.* YES ☐ NO ☐

15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service? YES ☐ NO ☐

Continuation Space / Agency Optional Questions

16. Provide details requested in items 7 through 15 and 18c in the space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed *(these questions are specific to your position and your agency is authorized to ask them).*

Certifications / Additional Questions

APPLICANT: If you are applying for a position and have not yet been selected, carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, read item 17, and complete 17a.

APPOINTEE: If you are being appointed, carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, read item 17, complete 17b, read 18, and answer 18a, 18b, and 18c as appropriate.

17. **I certify** that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith. **I understand that a false or fraudulent answer to any question or item on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand** that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. **I consent** to the release of information about my ability and fitness for Federal employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists, and other authorized employees or representatives of the Federal Government. **I understand** that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date.

17a. Applicant's Signature: _____ Date _____
(Sign in ink)

17b. Appointee's Signature _____ Date _____
(Sign in ink)

Appointing Officer:
Enter Date of Appointment or Conversion
MM / DD / YYYY

18. **Appointee (Only respond if you have been employed by the Federal Government before):** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

18a. When did you leave your last Federal job? DATE: MM / DD / YYYY

18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance? YES ☐ NO ☐ Do Not Know ☐

18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled. YES ☐ NO ☐ Do Not Know ☐

STANDARD FORM 61
Revised June 1986
U.S. Office of Personnel Management
FPM Chapter 296
61-108

APPOINTMENT AFFIDAVITS

_____ _____
(Position to which appointed) *(Date of appointment)*

_____ _____ _____
(Department or agency) *(Bureau or Division)* *(Place of employment)*

I, _____, do solemnly swear (or affirm) that—

A. OATH OF OFFICE

I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof.

C. AFFIDAVIT AS TO PURCHASE AND SALE OF OFFICE

I have not, nor has anyone acting in my behalf, given, transferred, promised or paid any consideration for or in expectation or hope of receiving assistance in securing this appointment.

_____
(Signature of appointee)

Subscribed and sworn (or affirmed) before me this _____ day of _____, 19_____,

at _____ _____
(City) *(State)*

[SEAL]

_____
(Signature of officer)

Commission expires _____

(If by a Notary Public, the date of expiration of his/her Commission should be shown)

_____
(Title)

NOTE.—*The oath of office must be administered by a person specified in 5 U.S.C. 2903. The words "So help me God" in the oath and the word "swear" wherever it appears above should be stricken out when the appointee elects to affirm rather than swear to the affidavits; only these words may be stricken and only when the appointee elects to affirm the affidavits.*

NSN 7540-00-634-4015

* U.S Government Printing Office1992- 321-950/69047

Prior Edition Usable

Request for DHHS Identification Card

ID No. *(assigned by DPS)*

1. Identification about the Employee

Last Name | First Name | Middle Name

Date of Birth | Institute or Center | Building and Room | Phone No.

2. Type of Request

- ☐ Initial request
- ☐ Renewal

Replacement:

- ☐ Lost
- ☐ Broken
- ☐ Stolen
- ☐ Name change

3. Authorizing Official

Name *(please type)*

Date of Request

Title

Institute or Center

Signature

4. Employee's Receipt of Identification Card

Employee's Signature

Date Received

Standard Form 50
Rev. 7/91
U.S. Offfice of Personnel Management
FPM Supp. 296-33, Subch. 4

NOTIFICATION OF PERSONNEL ACTION

1. Name *(Last, First, Middle)*	2. Social Security Number	3. Date of Birth	4. Effective Date

FIRST ACTION

5-A. Code	5-B. Nature of Action
5-C. Code	5-D. Legal Authority
5-E. Code	5-F. Legal Authority

SECOND ACTION

6-A. Code	6-B. Nature of Action
6-C. Code	6-D. Legal Authority
6-E. Code	6-F. Legal Authority

7. FROM: Position Title and Number

8. Pay Plan	9.Occ. Code	10.Grade or Level	11.Step or Rate	12. Total Salary	13.Pay Basis

12A. Basic Pay	12B. Locality Adj.	12C. Adj. Basic Pay	12D. Other Pay

14. Name and Location of Position's Organization

15. TO: Position Title and Number

16. Pay Plan	17. Occ Code	18.Grade or Level	19.Step or Rate	20. Total Salary/Award	21. Pay Basis

20A. Basic Pay	20B. Locality Adj.	20C. Adj. Basic Pay	20D. Other Pay

22. Name and Location of Position's Organization

EMPLOYEE DATA

23. Veterans Preference
1 - None 3 - 10-Point/Disability 5 - 10-Point/Other
2 - 5-Point 4 - 10-Point/Compensable 6 - 10-Point/Compensable/30%

24. Tenure
0 - None 2 - Conditional
1 - Permanent 3 - Indefinite

25. Agency Use

26. Veterans Pref for RIF
YES NO

27. FEGLI

28. Annuitant Indicator

29. Pay Rate Determinant

30. Retirement Plan

31. Service Comp. Date (Leave)

32. Work Schedule

33. Part-Time Hours Per Biweekly Pay Period

POSITION DATA

34. Position Occupied
1 - Competitive Service 3 - SES General
2 - Excepted Service 4 - SES Career

35. FLSA Category
E - Exempt
N - Nonexempt

36. Appropriation Code

37. Bargaining Unit Status

38. Duty Station Code

39. Duty Station *(City - County - State or Overseas Location)*

40. AGENCY DATA	41.	42.	43.	44.

45. Remarks

46. Employing Department or Agency			50. Signature/Authentication and Title of Approving Official
47. Agency Code	48. Personnel Office ID	49. Approval Date	

TURN OVER FOR IMPORTANT INFORMATION
5-Part

1 - Employee Copy - Keep for Future Reference

Editions Prior to 7/91 Are Not Usable After 6/30/93
NSN 7540-01-333-6236

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136
Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE. It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):
- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien # A _____)
- ☐ An alien authorized to work until _____ (Alien # or Admission # _____)

Employee's Signature	Date *(month/day/year)*

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparers/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification. To be completed and signed by employer.

Examine one document from List A OR examine one document from List B and one from List C as listed on the reverse of this form and record the title, number and expiration date, if any, of the document(s)

List A	OR	List B	AND	List C
Document title:				
Issuing authority:				
Document #:				
Expiration Date *(if any)*:				
Document #:				
Expiration Date *(if any)*:				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment).**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name *(if applicable)*	B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

Print pages 2 and 3 back-to-back.

Form W-4 (2001)

Purpose. Complete Form W-4 so your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7, and sign the form to validate it. Your exemption for 2001 expires February 18, 2002.

Note: *You cannot claim exemption from withholding if (1) your income exceeds $750 and includes more than $250 of unearned income (e.g., interest and dividends) and (2) another person can claim you as a dependent on their tax return.*

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. They will help you figure the number of withholding allowances you are entitled to claim. **However, you may claim fewer (or zero) allowances.**

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See **Pub. 919,** How Do I Adjust My Tax Withholding? for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using **Form 1040-ES,** Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2001. Get Pub. 919 especially if you used the **Two-Earner/Two-Job Worksheet** on page 2 and your earnings exceed $150,000 (Single) or $200,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 for a new social security card.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.

. . **B** _____

C Enter "1" for your **spouse.** But, you may choose to enter -0- if you are married and have either a working spouse or more than one job. (Entering -0- may help you avoid having too little tax withheld.) . . . . . **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . **E** _____

F Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit . . **F** _____
(**Note:** *Do **not** include child support payments. See **Pub. 503,** Child and Dependent Care Expenses, for details.*)

G **Child Tax Credit** (including additional child tax credit):
- If your total income will be between $18,000 and $50,000 ($23,000 and $63,000 if married), enter "1" for each eligible child.
- If your total income will be between $50,000 and $80,000 ($63,000 and $115,000 if married), enter "1" if you have two eligible children, enter "2" if you have three or four eligible children, or enter "3" if you have five or more eligible children. **G** _____

H Add lines A through G and enter total here. (**Note:** *This may be different from the number of exemptions you claim on your tax return.*) ► **H** _____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single,** have **more than one job** and your combined earnings from all jobs exceed $35,000, **or** if you are **married** and have a **working spouse or more than one job** and the combined earnings from all jobs exceed $60,000, see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **For Privacy Act and Paperwork Reduction Act Notice, see page 2.**

OMB No. 1545-0010
2001

1 Type or print your first name and middle initial	Last name	**2** Your social security number
Home address (number and street or rural route)		**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** *If married, but legally separated, or spouse is a nonresident alien, check the Single box.*
City or town, state, and ZIP code		**4** If your last name differs from that on your social security card, check here. You must call 1-800-772-1213 for a new card. ► ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5**

6 Additional amount, if any, you want withheld from each paycheck . . . . . **6** $

7 I claim exemption from withholding for 2001, and I certify that I meet **both** of the following conditions for exemption:
- Last year I had a right to a refund of **all** Federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** Federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ► **7**

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.

Employee's signature
(Form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number

Form
MW 507

Employee's Maryland Withholding Exemption Certificate

Comptroller of Maryland • Revenue Administration Division • Annapolis, Maryland 21411 • Phone 410-260-7980

Print your full name	Your Social Security number
Address (including ZIP code)	County of residence (or Baltimore City)

1. Total number of exemptions you are claiming from worksheet below 1._____

2. Additional withholding per pay period under agreement with employer 2._____

3. I claim exemption from withholding because (see instructions below and check boxes that apply)

☐ a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld,

AND

☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirement.)

If both **a** and **b** apply, enter year applicable _____ (year effective) Enter "EXEMPT" here 3._____

4. Certification of Nonresidence in the state of Maryland (see instructions on reverse side.) I certify that I am not domiciled in the state of Maryland, and that I do not maintain a place of abode within Maryland. I further certify that my permanent residence is:

_____ City, town or post office address _____ County _____ State Enter "EXEMPT" here 4._____

Under the penalty of perjury, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3 or line 4, whichever applies.

Employee's signature _____ Date _____

Employer's Name and Address (including zip code) (For employer use only)	Employer Identification Number

Worksheet and instructions

Line 1

A. Number of personal exemptions (total exemptions on lines A, C and D of the federal W-4 or W-4A worksheet). _____

B. Number of additional exemptions for dependents over 65 years of age. _____

C. Number of additional exemptions for estimated itemized deductions, alimony payments, allowable child care expenses, qualified retirement contributions, business losses and employee business expenses for the year. _____

D. Number of additional exemptions for taxpayer and/or spouse at least 65 years of age and/or blind. _____

E. Total - add lines A through D and enter here and on line 1 (Form MW 507). _____

EXEMPTIONS FOR DEPENDENTS To qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding taxable year.

ADDITIONAL EXEMPTIONS FOR DEPENDENTS OVER 65 YEARS OF AGE An additional exemption is allowed for dependents who are 65 years of age or older.

ADDITIONAL EXEMPTIONS You may claim additional exemptions for estimated itemized deductions, alimony payments, allowable child care expenses, qualified retirement contributions, business losses and employee business expenses for the year. One additional withholding exemption is permitted for each $2,100 of estimated itemized deductions or adjustments to income that exceed the standard deduction allowance.

NOTE: Standard deduction allowance is 15% of Maryland adjusted gross income with a minimum of $1,500 and a maximum of $2,000 for each taxpayer.

Retrieve Data

Reset Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES

RECORD OF HOME ADDRESS

INSTRUCTIONS FOR COMPLETING THE FORM ARE ON THE REVERSE SIDE

(1) Nature of Action

(2) Social Security Number

(3) Name

(Last) **(First)** **(M.I.)**

(4) Effective Date

//

(5) Street Address

(6) City

(7) County **(8) State** **(9) Zip-Code**

–

//

Employee Signature **Date**

PERSONNEL OFFICE USE ONLY

(10) Residence Location Code

(State) **(City)** **(County)**

HHS-476 (E) Revised 1/90
(CDC Adobe Acrobat 4.0 Electronic Version, 11/2000)

RETURN TO YOUR PERSONNEL OFFICE

IEF

Save Data

Print

Email Form

Standard Form 1199A (E), CDC Adobe Acrobat 4.0 Electronic Version, 6/2000
(Rev. June 1987)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007
Expiration Date 1-31-93

DIRECT DEPOSIT SIGN-UP FORM

Retrieve Data

Reset Form

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections I and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY | STATE | ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix | Social Security Number | Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire
- ☐ Mil. Survivor
- ☐ Other *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE | AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE | DATE // | SIGNATURE | DATE //

SIGNATURE | DATE // | SIGNATURE | DATE //

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME | GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER | CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME | SIGNATURE OF REPRESENTATIVE | TELEPHONE NUMBER | DATE //

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

Save Data | Print | Email Form

STATEMENT OF PRIOR FEDERAL SERVICE

To be Completed by Employee

1. Name (Last, First, Middle Initial)	2. Social Security Number	3. Date of Birth (Month, Day, Year)

4. Does the application or resume that you submitted, for the position to which you are being appointed, list all of your Federal government civilian and uniformed service, including beginning and ending dates, as well as the type of appointment and work schedule for civilian service?

☐ Yes — If "Yes", check this block and skip to Item 8. ☐ No — If "No", check this block and complete Items 5 - 9.

5. List below your prior civilian service. Include service with the DC Government on appointments made before October 1, 1987.

NAME AND LOCATION OF AGENCY	FROM			TO			TYPE OF APPOINTMENT AND WORK SCHEDULE (Full-Time, Part-Time, or Intermittent)
	Year	Month	Day	Year	Month	Day	

6. During periods of employment shown in Item 5, did you have a total of more than 6 months' absence without pay during any one calendar year?

☐ Yes — If "Yes", list the following information. ☐ No — If "No", go to Item 7.

TYPE OF ABSENCE, IF KNOWN (LWOP, Furlough, Suspension, AWOL, or Placement in Nonpay Status)	FROM			TO			TOTAL		
	Year	Month	Day	Year	Month	Day	YEARS	MONTHS	DAYS

7. List all uniformed service below. List active service in any branch of the Armed Forces of the United States, including active duty as a reservist, and active service in the commissioned corps of the Public Health Service or the National Oceanic and Atmospheric Administration.

BRANCH OF SERVICE	FROM			TO			DISCHARGE (Honorable or Dishonorable)
	Year	Month	Day	Year	Month	Day	

8. Do you claim any type of veterans' preference which has not been verified?

☐ No ☐ Yes — Check one of the statements, if it applies to you. I claim preference as the:
☐ Spouse of a disabled veteran ☐ Mother of a deceased or disabled veteran ☐ Unmarried widow/widower of a veteran

9. CERTIFICATION: The prior Federal civilian and uniformed service listed on my application/resume and listed above constitutes my entire record of Federal employment. I have no other Federal service for which I want to claim credit.

Signature	Date

*U.S. Government Printing Office: 1996 - 404-761/32401

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Standard Form 85 (E), CDC Adobe Acrobat 4.0 Electronic Version, 8/2000
Revised September 1995
U.S. Office of Personnel Management
5 CFR Parts 731 and 736

Form approved:
OMB No. 3206-0005
NSN 7540-00-634-4035
85-111

UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF INFORMATION

Carefully read this authorization to release information about you, then sign and date it in black ink.

I Authorize any investigator, special agent, or other duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain any information relating to my activities from schools, residential management agents, employers, criminal justice agencies, retail business establishments, or other sources of information. This information may include, but is not limited to, my academic, residential, achievement, performance, attendance, disciplinary, employment history, and criminal history record information.

I Understand that, for some sources of information, a separate specific release will be needed, and I may be contacted for such a release at a later date.

I Authorize custodians of records and sources of information pertaining to me to release such information upon request of the investigator, special agent, or other duly accredited representative of any Federal agency authorized above regardless of any previous agreement to the contrary.

I Understand that the information released by records custodians and sources of information is for official use by the Federal Government only for the purposes provided in this Standard Form 85, and may be redisclosed by the Government only as authorized by law.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid for two (2) years from the date signed.

Signature *(Sign in ink)*	Full Name *(Type or Print Legibly)*		Date Signed //
Other Names Used			Social Security Number
Current Address *(Street, City)*	State	ZIP Code	Home Telephone Number *(Include Area Code)*

Save Data Print Email Form

Retrieve Data

Reset Form

Standard Form 85 (E), CDC Adobe Acrobat 4.0 Electronic Version, 8/2000
Revised September 1995
U.S. Office of Personnel Management
5 CFR Parts 731 and 736

QUESTIONNAIRE FOR NON-SENSITIVE POSITIONS

Form approved:
OMB No. 3206-0005
NSN 7540-00-634-4035
85-111

OPM USE ONLY | Codes | Case Number

Agency Use Only ***(Complete items A through K using instructions provided by USOPM)***

A Type of Investigation	B Extra Coverage	C Nature of Action Code	D Date of Action	Month	Day	Year

E Geographic Location	F Position Title	G SON	H SOI

I OPAC-ALC Number	J Accounting Data and/or Agency Case Number

K Requesting Official	Name and Title	Signature	Telephone Number	Date
				//

Persons completing this form should begin with the questions below.

1 FULL NAME
- If you have only initials in your name, use them and state (IO).
- If you have no middle name, enter "NMN".
- If you are a "Jr.," "Sr.," "II," etc., enter this in the box after your middle name.

2 DATE OF BIRTH

Last Name	First Name	Middle Name	Jr., II, etc.	Month	Day	Year

3 PLACE OF BIRTH - Use the two letter code for the State.

City	County	State	Country *(if not in the United States)*

4 SOCIAL SECURITY

5 OTHER NAMES USED
Give other names you used and the period of time you used them *(for example: your maiden name, name(s) by a former marriage, former name(s), alias(es), or nickname(s))*. If the other name is your maiden name, put "nee" in front of it.

	Name	Month/Year	Month/Year
#1		/	To /
#2		/	To /
#3		/	To /
#4		/	To /

6 SEX *(Mark one box)*

Female ☐ Male ☐

7 CITIZENSHIP

a Mark the box at the right that reflects your current citizenship status, and follow its instructions.

- ☐ I am a U.S. citizen or national by birth in the U.S. or U.S. territory/possession. *(Answer items b and d)*
- ☐ I am a U.S. citizen, but I was NOT born in the U.S. *(Answer items b , c and d)*
- ☐ I am not a U.S. citizen. *(Answer items b and e)*

b Your Mother's Maiden Name

c UNITED STATES CITIZENSHIP If you are a U.S. citizen, but were not born in the U.S., provide information about one or more of the following proofs of your citizenship.

Naturalization Certificate *(Where were you naturalized?)*

Court	City	State	Certificate Number	Month/Day/Year Issued

Citizenship Certificate *(Where was the certificate issued?)*

City	State	Certificate Number	Month/Day/Year Issued

State Department Form 240 - Report of Birth Abroad of a Citizen of the United States

Give the date the form was prepared and give an explanation if needed	Month/Day/Year	Explanation

U.S. Passport

This may be either a current or previous U.S. Passport.	Passport Number	Month/Day/Year Issued

d DUAL CITIZENSHIP If you are (or were) a dual citizen of the United States and another country, provide the name of that country in the space to the right. Country

e ALIEN If you are an alien, provide the following information:

Place You Entered the United States:	City	State	Date You Entered U.S. Month	Day	Year	Alien Registration Number	Country(ies) of Citizenship

Exception to SF85, SF85P, SF85P-S, SF86, and SF86A approved by GSA September, 1995.
Designed using Perform Pro, WHS/DIOR, Sep 95

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8 WHERE YOU HAVE LIVED

List the places where you have lived, beginning with the most recent (#1) and working back 5 years. All periods must be accounted for in your list. Be sure to indicate the actual physical location of your residence: do not use a post office box as an address, do not list a permanent address when you were actually living at a school address, etc. Be sure to specify your location as closely as possible: for example, do not list only your base or ship, list your barracks number or home port. You may omit temporary military duty locations under 90 days (list your permanent address instead), and you should use your APO/FPO address if you lived overseas.

For any address in the last 3 years, list a person who knew you at that address, and who preferably still lives in that area (do not list people for residences completely outside this 3-year period, and do not list your spouse, former spouses, or other relatives).

	Month/Year	Month/Year	Street Address	Apt. #	City (Country)	State	ZIP Code
#1	/	To Present					
	Name of Person Who Knows You		Street Address	Apt. #	City (Country)	State	ZIP Code
#2	Month/Year /	Month/Year To /	Street Address	Apt. #	City (Country)	State	ZIP Code
	Name of Person Who Knew You		Street Address	Apt. #	City (Country)	State	ZIP Code
#3	Month/Year /	Month/Year To /	Street Address	Apt. #	City (Country)	State	ZIP Code
	Name of Person Who Knew You		Street Address	Apt. #	City (Country)	State	ZIP Code
#4	Month/Year /	Month/Year To /	Street Address	Apt. #	City (Country)	State	ZIP Code
	Name of Person Who Knew You		Street Address	Apt. #	City (Country)	State	ZIP Code
#5	Month/Year /	Month/Year To /	Street Address	Apt. #	City (Country)	State	ZIP Code
	Name of Person Who Knew You		Street Address	Apt. #	City (Country)	State	ZIP Code

9 WHERE YOU WENT TO SCHOOL

List the schools you have attended, beyond Junior High School, **beginning with the most recent (#1) and working back 5 years.** List all College or University degrees and the dates they were received. If all of your education occurred more than 5 years ago, list your most recent education beyond high school, no matter when that education occurred.

- Use one of the following codes in the "Code" block:

1 - High School **2 -** College/University/Military College **3 -** Vocational/Technical/Trade School

- For correspondence schools and extension classes, provide the address where the records are maintained.

	Month/Year	Month/Year	Code	Name of School	Degree/Diploma/Other	Month/Year Awarded
#1	/	To /				/
	Street Address and City (Country) of School				State	ZIP Code
#2	Month/Year /	Month/Year To /	Code	Name of School	Degree/Diploma/Other	Month/Year Awarded /
	Street Address and City (Country) of School				State	ZIP Code
#3	Month/Year /	Month/Year To /	Code	Name of School	Degree/Diploma/Other	Month/Year Awarded /
	Street Address and City (Country) of School				State	ZIP Code

Enter your Social Security Number before going to the next page →

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10 YOUR EMPLOYMENT ACTIVITIES

List your employment activities, beginning with the present (#1) and working back 5 years. You should list all full-time work, part-time work, military service, temporary military duty locations over 90 days, self-employment, other paid work, and all periods of unemployment. The entire 5-year period must be accounted for without breaks, but you need not list employments before your 16th birthday.

- **Code.** Use one of the codes listed below to identify the type of employment:
  - **1** - Active military duty stations
  - **2** - National Guard/Reserve
  - **3** - U.S.P.H.S. Commissioned Corps
  - **4** - Other Federal employment
  - **5** - State Government (Non-Federal employment)
  - **6** - Self-employment (Include business name and/or name of person who can verify)
  - **7** - Unemployment (Include name of person who can verify)
  - **8** - Federal Contractor (List Contractor, not Federal agency)
  - **9** - Other
- **Employer/Verifier Name.** List the business name of your employer or the name of the person who can verify your self-employment or unemployment in this block. If military service is being listed, include your duty location or home port here as well as your branch of service. You should provide separate listings to reflect changes in your military duty locations or home ports.
- **Previous Periods of Activity.** Complete these lines if you worked for an employer on more than one occasion at the same location. After entering the most recent period of employment in the initial numbered block, provide previous periods of employment at the same location on the additional lines provided. For example, if you worked at XY Plumbing in Denver, CO, during 3 separate periods of time, you would enter dates and information concerning the most recent period of employment first, and provide dates, position titles, and supervisors for the two previous periods of employment on the lines below that information.

#1 Month/Year / To Month/Year Present	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank
Employer's/Verifier's Street Address	City (Country)	State	ZIP Code	Telephone Number
Street Address of Job Location (if different than Employer's Address)	City (Country)	State	ZIP Code	Telephone Number
Supervisor's Name & Street Address (if different than Job Location)	City (Country)	State	ZIP Code	Telephone Number

PREVIOUS PERIODS OF ACTIVITY (Block #1)	Month/Year / To Month/Year /	Position Title	Supervisor
	Month/Year / To Month/Year /	Position Title	Supervisor
	Month/Year / To Month/Year /	Position Title	Supervisor

#2 Month/Year / To Month/Year /	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank
Employer's/Verifier's Street Address	City (Country)	State	ZIP Code	Telephone Number
Street Address of Job Location (if different than Employer's Address)	City (Country)	State	ZIP Code	Telephone Number
Supervisor's Name & Street Address (if different than Job Location)	City (Country)	State	ZIP Code	Telephone Number

PREVIOUS PERIODS OF ACTIVITY (Block #2)	Month/Year / To Month/Year /	Position Title	Supervisor
	Month/Year / To Month/Year /	Position Title	Supervisor
	Month/Year / To Month/Year /	Position Title	Supervisor

#3 Month/Year / To Month/Year /	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank
Employer's/Verifier's Street Address	City (Country)	State	ZIP Code	Telephone Number
Street Address of Job Location (if different than Employer's Address)	City (Country)	State	ZIP Code	Telephone Number
Supervisor's Name & Street Address (if different than Job Location)	City (Country)	State	ZIP Code	Telephone Number

PREVIOUS PERIODS OF ACTIVITY (Block #3)	Month/Year / To Month/Year /	Position Title	Supervisor
	Month/Year / To Month/Year /	Position Title	Supervisor
	Month/Year / To Month/Year /	Position Title	Supervisor

Enter your Social Security Number before going to the next page →

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YOUR EMPLOYMENT ACTIVITIES *(CONTINUED)*

	Month/Year	Month/Year	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank
#4	/ To	/			

Employer's/Verifier's Street Address	City (Country)	State	ZIP Code	Telephone Number
Street Address of Job Location (if different than Employer's Address)	City (Country)	State	ZIP Code	Telephone Number
Supervisor's Name & Street Address (if different than Job Location)	City (Country)	State	ZIP Code	Telephone Number

PREVIOUS PERIODS OF ACTIVITY *(Block #4)*	Month/Year	Month/Year	Position Title	Supervisor
	/ To	/		
	/ To	/		
	/ To	/		

	Month/Year	Month/Year	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank
#5	/ To	/			

Employer's/Verifier's Street Address	City (Country)	State	ZIP Code	Telephone Number
Street Address of Job Location (if different than Employer's Address)	City (Country)	State	ZIP Code	Telephone Number
Supervisor's Name & Street Address (if different than Job Location)	City (Country)	State	ZIP Code	Telephone Number

PREVIOUS PERIODS OF ACTIVITY *(Block #5)*	Month/Year	Month/Year	Position Title	Supervisor
	/ To	/		
	/ To	/		
	/ To	/		

	Month/Year	Month/Year	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank
#6	/ To	/			

Employer's/Verifier's Street Address	City (Country)	State	ZIP Code	Telephone Number
Street Address of Job Location (if different than Employer's Address)	City (Country)	State	ZIP Code	Telephone Number
Supervisor's Name & Street Address (if different than Job Location)	City (Country)	State	ZIP Code	Telephone Number

PREVIOUS PERIODS OF ACTIVITY *(Block #6)*	Month/Year	Month/Year	Position Title	Supervisor
	/ To	/		
	/ To	/		
	/ To	/		

11 PEOPLE WHO KNOW YOU WELL

List three people who know you well and live in the United States. They should be good friends, peers, colleagues, college roommates, etc., whose combined association with you covers as well as possible the last 5 years. Do not list your spouse, former spouses, or other relatives, and try not to list anyone who is listed elsewhere on this form.

Name **#1**	Dates Known Month/Year / To Month/Year /	Telephone Number Day Night
Home or Work Address	City (Country)	State ZIP Code

Name **#2**	Dates Known Month/Year / To Month/Year /	Telephone Number Day Night
Home or Work Address	City (Country)	State ZIP Code

Name **#3**	Dates Known Month/Year / To Month/Year /	Telephone Number Day Night
Home or Work Address	City (Country)	State ZIP Code

Enter your Social Security Number before going to the next page

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12 YOUR SELECTIVE SERVICE RECORD

	Yes	No
a Are you a male born after December 31, 1959? If "No," go to 13. If "Yes," go to b.	☐	☐
b Have you registered with the Selective Service System? If "Yes," provide your registration number. If "No," show the reason for your legal exemption below.		

Registration Number

Legal Exemption Explanation

13 YOUR MILITARY HISTORY

	Yes	No
a Have you served in the United States military?	☐	☐
b Have you served in the United States Merchant Marine?	☐	☐

List all of your military service below, including service in Reserve, National Guard, and U.S. Merchant Marine. Start with the most recent period of service (#1) and work backward. If you had a break in service, each separate period should be listed.

Code. Use one of the codes listed below to identify your branch of service:

1 - Air Force **2** - Army **3** - Navy **4** - Marine Corps **5** - Coast Guard **6** - Merchant Marine **7** - National Guard

O/E. Mark "O" block for Officer or "E" block for Enlisted.

Status. "X" the appropriate block for the status of your service during the time that you served. If your service was in the National Guard, do not use an "X"; use the two-letter code for the state to mark the block.

Country. If your service was with other than the U.S. Armed Forces, identify the country for which you served.

Month/Year	Month/Year	Code	Service/Certificate #	O	E	Status				Country
						Active	Active Reserve	Inactive Reserve	National Guard *(State)*	
	To									
	To									

14 ILLEGAL DRUGS

	Yes	No
In the last year, have you used, possessed, supplied, or manufactured illegal drugs? When used without a prescription, illegal drugs include marijuana, cocaine, hashish, narcotics (opium, morphine, codeine, heroin, etc.), stimulants (cocaine, amphetamines, etc.), depressants (barbiturates, methaqualone, tranquilizers, etc.). hallucinogenics (LSD, PCP, etc.). (NOTE: Neither your truthful response nor information derived from your response will be used as evidence against you in any subsequent criminal proceeding.)	☐	☐

If you answered "Yes," provide information relating to the types of substance(s), the nature of the activity, and any other details relating to your involvement with illegal drugs. Include any treatment or counseling received.

Month/Year	Month/Year	Type of Substance	Explanation
/ To	/		
/ To	/		
/ To	/		

Continuation Space

Use the continuation sheet(s) (SF86A) for additional answers to items 8, 9, and 10. Use the space below to continue answers to all other items and any information you would like to add. If more space is needed than is provided below, use a blank sheet(s) of paper. Start each sheet with your name and Social Security number. Before each answer, identify the number of the item.

After completing this form you should review your answers to all questions to make sure the form is complete and accurate, and then sign and date the following certification and sign and date the release on Page 6.

Certification That My Answers Are True

My statements on this form, and any attachments to it, are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I understand that a knowing and willful false statement on this form can be punished by fine or imprisonment or both. (See section 1001 of title 18, United States Code).

Signature *(Sign in ink)*

Date

//

Enter your Social Security Number before going to the next page →

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SF 87 (REV. 4/98)
U.S. OFFICE OF PERSONNEL MANAGEMENT
E.O. 10450

LEAVE BLANK

TYPE OR PRINT ALL INFORMATION IN BLACK

LAST NAME NAM | FIRST NAME | MIDDLE NAME

FBI | LEAVE BLANK

SIGNATURE OF PERSON FINGERPRINTED

O
R
I

USOPMOOOZ - FIPC BOYERS, PA

RESIDENCE OF PERSON FINGERPRINTED

SERIAL NO. (OPM USE ONLY) OCA

DATE OF BIRTH DOB
MONTH | DAY | YEAR

ALIASES AKA

SEX | RACE | HGT. | WGT. | EYES | HAIR | PLACE OF BIRTH POB

DATE | SIGNATURE OF OFFICAL TAKING FINGERPRINTS

LEAVE BLANK

TITLE AND ADDRESS

SCARS, MARKS, AND TATTOOS

CLASS.

POSITION TO WHICH APPOINTED

FBI NO. FBI

REF.

DEPARTMENT, BUREAU, AND DUTY STATION (CITY AND STATE)

SOCIAL SECURITY NO. SOC

1. R. THUMB	2. R. INDEX	3. R. MIDDLE	4. R. RING	5. R. LITTLE
6. L. THUMB	7. L. INDEX	8. L. MIDDLE	9. L. RING	10. L. LITTLE

LEFT FOUR FINGERS TAKEN SIMULTANEOUSLY | L. THUMB | R. THUMB | RIGHT FOUR FINGERS TAKEN SIMULTANEOUSLY

FEHB
Federal Employees Health Benefits Program

Health Benefits Election Form

Federal Employees Health Benefits Program

Form Approved: OMB No. 3206-0239

For **Annuitants (other than CSRS/FERS), Compensationers, Former Spouses Under the Spouse Equity Law, and Individuals Eligible for Temporary Continuation of Coverage**

* *Complete Parts A and F and Parts B, C, D, and E as applicable.*

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

* *Type or print firmly*
* *Sign and date in Part F.*

Part A - *Fill in this part.*

1. Name *(last, first, middle initial)*	2. Social Security Number	3. Date of birth *(mo., day, yr.)*
4. Your home mailing address *(include ZIP code)*	5. Sex ☐ Male ☐ Female	6. Are you now married? ☐ Yes ☐ No
	7. Daytime telephone number *(including area code)*	

Part B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. *(Copy the information requested below from front cover of brochure of the plan you select.)*

Name of plan *(you want to enroll in)* | Enrollment code

2a. Names of family members *(last, first, middle initial)*	2b. ZIP code	2c. Date of birth *(mo., day, yr.)*	2d. Sex	2e. Relationship "code"	2f. Social Security Number *(see instructions)*

3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? ☐ No ☐ Yes → Complete 3b

Name of policyholder *(last, first, middle initial)*

3b. Type of insurance Medicare *You* ☐ A ☐ B *Your spouse* ☐ A ☐ B ☐ TRICARE (Including Champus) ☐ Other *(specify name)*

Part C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name *(the plan you are leaving)*	2. Present Plan enrollment code

Part D - *Event*

3. Event code that permits change *(see Table of Permissible Changes)*	4. Date of event that permits change *(mo., day, yr.)*

PART E - *Cancellation*

Place an "X" in the box below if you wish to CANCEL your enrollment.

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently under the code shown here → Present Plan enrollment code

My signature in PART F certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment.

Part F - *Fill in this part*

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*	2. Date *(mo., day, yr.)*

Part G - *To be completed by agency*

1. Name and address of employing office *(include ZIP code)*	2. Date received in employing office *(mo., day, yr.)*	3. Effective date of action *(mo., day, yr.)*	4. SF 2811 report number
	5. Payroll office number	6. Payroll contact and telephone number *(including area code)*	
	7. Personnel contact and telephone number *(including area code)*		
	8. Signature of authorized agency official and telephone number *(including area code)*		

Remarks

FEGLI
Federal Employees Group Life Insurance

Life Insurance Election

Federal Employees' Group Life Insurance Program

See Privacy Act Statement on back of Part 3

Form Approved:
OMB NO. 3206-0230

1 General Instructions:

By law, unless you waive all coverage or are ineligible, you are automatically covered for Basic Life insurance as an employee. When you first become eligible for FEGLI, you may (1) elect Basic and any or all of the options, (2) elect Basic but decline all of the options, or (3) waive all life insurance coverage. If you are changing a previous election, see the back of Part 3 - Employee Copy.

- Read the back of Part 3 - Employee Copy carefully
- Assignees completing this form should read Items 5 and 6 on the back of Part 3.
- Do not separate the parts. Give this form to your employing office which will complete the form and return your copy to you.

This election supersedes all previous elections.

2 Fill in identifying information concerning the employee.

Name (Last, First, Middle)	Date of birth (mm/dd/yyyy)	Social Security Number

Employing department or agency	OWCP claim number, if applicable	Department or agency location where employee works (City, state, ZIP Code)

3 To elect or retain Basic, sign and date below. If you do not sign for Basic, you may not elect or retain any form of optional insurance. If you do not want any insurance at all, skip to Section 5.

Basic

I want Basic. I authorize deductions to pay my share of the cost. (Basic may be provided without cost to Postal Service employees.)

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →

Date *(mm/dd/yyyy)*

4 Optional

If you signed for Basic in item 3 above, you may elect or retain any or all of the following options (UNLESS you have previously waived any or all of these options, in which case you may elect only those options which you are eligible to elect as outlined in the FEGLI booklet). Sign the box(es) below for any option(s) you are eligible for and wish to elect or retain. If you waive one or more of the options, your future opportunities to enroll in it are strictly limited. **You will not be covered for any option(s) for which you do not sign below, regardless of whether you previously elected the option(s).**

Option A - Standard	Option B - Additional	Option C - Family
I want Option A. I authorize deductions to pay the full cost.	I want Option B in the multiple of my annual basic pay I indicate below. I authorize deductions to pay the full cost. ☐ 1 times my pay ☐ 2 times my pay ☐ 3 times my pay ☐ 4 times my pay ☐ 5 times my pay	I want Option C in the multiple I indicate below. I understand that **each** multiple is worth $5,000 upon the death of my spouse, and $2,500 upon the death of an eligible child. I authorize deductions to pay the full cost. ☐ 1 multiple ☐ 2 multiples ☐ 3 multiples ☐ 4 multiples ☐ 5 multiples
Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →	**Signature** *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →	**Signature** *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* →
Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*

5 If you want NO life insurance coverage, sign and date below.

Waiver of all life insurance coverage

I want no life insurance coverage. I understand that any life insurance I have will stop at the end of the last day of the pay period in which my employing office receives this waiver. Further, I cannot get Basic life insurance unless (1) I wait at least 1 year after I sign this form **and** submit satisfactory results of a physical, or (2) I have a break in Federal service of at least 180 days, or (3) I participate in an open enrollment period, which is held infrequently. I understand that I cannot get any optional insurance unless I first have Basic. I understand that my decision to waive life insurance coverage now may affect my eligibility for coverage as a retiree.

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable)* →

Date *(mm/dd/yyyy)*

6 To be completed by agency.

Remarks:

Number of event permitting change *(See tback of Part 2)* →

Name and address of employing office	Date received in employing office *(mm/dd/yyyy)*	Effective date of coverage *(mm/dd/yyyy)*

I followed the instructions on the back of Part 1.

Signature of authorized agency official

The employee's copy of this form, when completed by the employing office, together with the FEGLI booklet. (RI 76-21 or RI 76-20 for Postal Service employees) constitute the employee's Certificate of Insurance.

PART 1 - File in Official Personnel Folder

Standard Form 2817
Rev. April 1999

NSN 7540-01-231-4280

Print pages 2 and 3 back-to-back.

THRIFT SAVINGS PLAN
ELECTION FORM

TSP-1

Use this form to:
- Start your contributions to the Thrift Savings Plan (TSP)
- Change the amount of your contributions to the TSP
- Stop your contributions to the TSP

Before completing this form, please read the *Summary of the Thrift Savings Plan for Federal Employees* and the instructions on the back of this form. Type or print all information using black or dark blue ink. **Return the completed form to your agency employing office.** Your agency will return a copy to you after completing Section V.

Note: To allocate your contributions among the five investment funds, see the instructions in the General Information section on the back of this form.

I. INFORMATION ABOUT YOU

1. Name *(Last)* _____ *(First)* _____ *(Middle)* _____

2. Street Address _____ City _____ State _____ Zip Code _____

3. _____ – _____ – _____ Social Security Number

4. (_____) _____ – _____ Daytime Phone *(Area Code and Number)*

5. Office Identification *(Agency and Organization)* _____

II. START OR CHANGE YOUR CONTRIBUTIONS

To start or change the amount of your contributions to your TSP account, enter **either** a whole percentage of your basic pay per pay period (Item 6) **or** a whole dollar amount per pay period (Item 7). Skip to Section IV.

6. _____.0% **OR** **7.** $ _____.00

III. STOP YOUR CONTRIBUTIONS

To stop your contributions to the TSP, check Item 8 and complete Section IV. (If you are a FERS employee and you are eligible to receive Agency Automatic (1%) Contributions, those 1% contributions will continue. Read the instructions on the back.)

8. ☐ I want to stop contributing to my TSP account. I understand that my payroll contributions will stop no later than the first full pay period after my agency employing office receives this form.

IV. SIGNATURE

9. Participant's Signature _____

10. Date Signed *(mm/dd/yyyy)* ___/___/_____

V. FOR EMPLOYING OFFICE USE ONLY

11. _____ Payroll Office Number

12. ___/___/_____ Effective Date *(mm/dd/yyyy)*

13. ___/___/_____ New Eligibility Date *(mm/dd/yyyy)* *(If participant completed Section III)*

14. _____ Signature of Employing Office Official

15. ___/___/_____ Receipt Date *(mm/dd/yyyy)*

16. _____ Remarks

PRIVACY ACT NOTICE. We are authorized to request this information under 5 U.S.C. Chapter 84. Executive Order 9397 authorizes us to ask for your Social Security number, which will be used to identify your account. We will use the information you provide to process your TSP election. This information may be shared with other Federal agencies for statistical, auditing, or archiving purposes. In addition, we may share the information with law enforcement agencies investigating a violation of civil or criminal law, or agencies implementing a statute, rule, or order. It may be shared with congressional offices, private sector audit firms, spouses, former spouses, and beneficiaries. We may also disclose relevant portions of the information to appropriate parties engaged in litigation. You are not required by law to provide this information, but if you do not provide it, we will not be able to process your request.

ORIGINAL TO PERSONNEL FOLDER
Provide a copy to the employee and to the payroll office.

Form TSP-1 (5/2001)
PREVIOUS EDITIONS OBSOLETE

Welfare to Work Program

(Please read the instructions and Privacy Act Statement before completing form)

Agency Use Only	Name (Last, First, Middle Initial)	Social Security Number
		___-___-____

Specific Instructions:

The categories below are designed to identify whether or not you are receiving assistance under the Temporary Assistance to Needy Families Program. Place an "X" in the box next to the appropriate category.

Category (Mark ONE only)	**DEFINITION OF CATEGORY**
A ☐	I am an adult, or teen parent under age 19, receiving assistance under: a) The Temporary Assistance for Needy Families (TANF) program administered by a State under the Federal block grant; **OR** b) Aid to Families with Dependent Children (AFDC); **OR** c) Tribal Temporary Assistance for Needy Families program administered by an eligible Indian tribe.
B ☐	I am not currently receiving this type of assistance.

Privacy Act Statement

Furnishing this information is voluntary. Solicitation of this information is authorized by President Clinton's Memorandum of March 8, 1997 entitled "Government Employment for Welfare Recipients." This information will be used for workforce analysis and for monitoring agencies' compliance with the President's Memorandum. This information may also be used for statistical reports. It will not be used to make any personnel decisions about individuals.

Executive Order 9397 (November 22, 1943) authorizes use of your Social Security Number (SSN). That Order requires agencies to use the SSN for the orderly administration of personnel records. Your SSN will be used solely for that purpose. Your furnishing of your SSN is voluntary and failure to furnish it will have no effect on you.

FERS
Federal Employees Retirement System

Designation of Beneficiary

Federal Employees' Retirement System

FormApproved:
OMB No. 3206-0173

Important

Read all instructions before filling in this form

A. Identification

Name *(Last, first, middle)*	Date of birth *(Month, day, year)*	Social Security Number

Place an "X" in the appropriate box: →	☐ An employee	☐ Retired or an applicant for retirement	☐ Former employee eligible for retirement in the future	If you are retired give your claim number

Department or agency in which presently employed *(or former department or agency):*

Department or agency	*Bureau*	*Division*	*Location (City, state and ZIP code)*

I, the individual identified above, designate the beneficiary or beneficiaries named below to receive any lump-sum benefit which may become payable under the Federal Employees' Retirement System (FERS) after my death. I understand that this designation of beneficiary is also for any lump-sum benefit which may become payable under the Civil Service Retirement System (CSRS) after my death. I understand that this designation of beneficiary cancels my previous FERS or CSRS designation of beneficiary, and that it remains in effect until I cancel it in writing or I receive payment of my employee deductions for FERS (and CSRS, if applicable).

I direct, unless otherwise indicated below, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or who may be disqualified for any other reason, shall be distributed equally among the stated beneficiaries, or entirely to the survivor. If none of the beneficiaries are alive and eligible to receive payment when a lump-sum payment becomes payable, this designation is void, and payment will be made according to the order of precedence set by law.

B. Information Concerning The Beneficiaries (See Examples of Designations):

First name, middle initial, and last name of each beneficiary	Address (Including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Date of this designation *(Mo., day, yr.)*	Your signature		Total = 100%

C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness	Number and street	City, state, ZIP code
Signature of witness	Number and street	City, state, ZIP code

Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date Received	*Signature*	*Date*

Type or print your return address to insure return of copy

See Back of Employee Copy For Instructions On Where To File This Form. (Retain until employee leaves Federal service and then send to OPM)

Print pages 2 and 3 back-to-back.

THRIFT SAVINGS PLAN
DESIGNATION OF BENEFICIARY

TSP-3

Under this form to designate a beneficiary or beneficiaries to receive your Thrift Savings Plan (TSP) account after your death. **Read the instructions on the back to assist you in completing this form.** Type or print the information requested. Do not alter this form or the information you enter; if you need to make a correction or change your entries, start over on a new form.

I. INFORMATION ABOUT YOU

1. Name _____
   Last First Middle

2. _____ 3. _____ 4. _____
   Social Security Number | Date of Birth *(Month/Day/Year)* | Daytime Phone *(Area Code and Number)*

5. Address _____
   Street address or box number

6. City _____ 7. _____ 8. _____
   State Zip Code

II. DESIGNATING YOUR BENEFICIARIES

Indicate in whole percentages or fractions the share of your TSP account to be paid to each beneficiary.

1. _____ **Share:** _____
   Beneficiary Name *(Last)* *(First)* *(Middle)*
   Street address or box number
   City State Zip Code
   Social Security Number/EIN | Date of Birth *(Month/Day/Year)* | Relationship

2. _____ **Share:** _____
   Beneficiary Name *(Last)* *(First)* *(Middle)*
   Street address or box number
   City State Zip Code
   Social Security Number/EIN | Date of Birth *(Month/Day/Year)* | Relationship

3. _____ **Share:** _____
   Beneficiary Name *(Last)* *(First)* *(Middle)*
   Street address or box number
   City State Zip Code
   Social Security Number/EIN | Date of Birth *(Month/Day/Year)* | Relationship

☐ Check here if additional pages are used. Number of additional pages _____. (See back of form.)

III. YOUR SIGNATURE

Sign and date this section. Your signature must be witnessed in Section IV.

_____ _____
Participant's Signature | Date Signed

IV. WITNESSES TO SIGNATURE

This form is valid only if it is witnessed by two persons. The witnesses must be age 21 or older. (A witness cannot be a beneficiary of any portion of your TSP account.) By signing below, the witnesses affirm that the participant (a) signed Section III in their presence, or (b) informed them that the signature in Section III is the participant's own signature.

Witness **1** _____ _____
Typed or Printed Name of First Witness | Signature of First Witness

Witness **2** _____ _____
Typed or Printed Name of Second Witness | Signature of Second Witness

Form TSP-3 (Revised 10/96)
PREVIOUS EDITIONS OBSOLETE

Print pages 2 and 3 back-to-back.

FEGLI
Federal Employees Group Life Insurance

Designation of Beneficiary
Federal Employees' Group Life Insurance (FEGLI) Program
(DO NOT erase or cross-out. Use a new form.)

Form Approved
OMB No. 3206-0136

Important:
Read instructions on the Back of Part 2 before completing this form.

A. Information About the Insured (not the Assignee, if there is one) (type or print)

Name of Insured *(Last, first, middle)*

Date of birth of Insured *(mm/dd/yyyy)*

Social Security Number of Insured

The Insured is:
Place an "X" in the appropriate box.
- ☐ an employee
- ☐ a retiree
- ☐ a compensationer

If the Insured is retired or receiving Federal Employees' Compensation, give CSA, CSI, or OWCP claim number:

Department or agency where the Insured works *(If retired, last department or agency where the Insured worked):*

Department or agency

Bureau or division

Location *(city, state, and ZIP code)*

B. Information About the Beneficiary or Beneficiaries (See Back of Part 1 for examples) (type or print)

First name, middle initial, and last name of each beneficiary	Social Security Number	Address *(Including ZIP code)*	Relationship	Percent or fraction designated

Total (Must equal 100% or 1.0) (Do not use dollar amounts)
(Do not put a Total if you designated types of insurance. See example 4 on Back of Part 1.)

C. Statement of Insured or Assignee (type or print)

Your name and address *(Including ZIP code)*

Please check one:
I am:
- ☐ the Insured
- ☐ an Assignee

See Back of Part 2 for definitions

Please check all three:
- ☐ I have not assigned the insurance.
- ☐ Two people who witnessed my signature signed below.
- ☐ I did not name either witness as a beneficiary.

I understand that if there is a valid assignment on file, only the assignee has the right to designate a beneficiary. If a valid assignment is not on file, but there is a valid court order on file with the agency or the U.S. Office of Personnel Management, as appropriate, any designation I complete for the same benefits is not valid.

I understand that if this Designation is valid, it will stay in effect unless it is canceled. (See "When Is A Designation Canceled?" on the Back of Part 2).

I understand that if this Designation is invalid for any reason, the Office of Federal Employees' Group Life Insurance will pay benefits according to the next most recent valid designation. If there isn't one, it will pay according to the order listed on the Back of Part 2.

I am canceling any and all previous Designations of Beneficiary under the Federal Employees' Group Life Insurance Program and am now designating the beneficiary(ies) named above.

Signature of Insured/Assignee *(Only the Insured/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* This form is not valid unless the Insured/Assignee signs in this box.

Date *(mm/dd/yyyy)*

D. Witnesses To Signature (A witness is not eligible to receive a payment as a beneficiary.)

Signature of witness	Address *(Including ZIP code)*
Signature of witness	Address *(Including ZIP code)*

E. For Agency Use Only

Receiving agency	Date of receipt *(mm/dd/yyyy)*	Signature of authorized agency official	Title

Standard Form 1152
(Rev. 11-91)
Title 4, GAO Manual
1152-108
NSN 7540-00-634-4340

DESIGNATION OF BENEFICIARY

UNPAID COMPENSATION OF DECEASED CIVILIAN EMPLOYEE

IMPORTANT
Read instructions on back of duplicate before filling in this form

INFORMATION CONCERNING THE EMPLOYEE:

NAME (Last) (First) (Middle)	DATE OF BIRTH (month, day, year)
	Social Security Number

DEPARTMENT OR AGENCY IN WHICH EMPLOYED

(Department or agency) (Bureau) (Division)

I, the employee named above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any UNPAID COMPENSATION due and payable after my death. I understand that this Designation of Beneficiary relates solely to money due as defined in 5 U.S.C. 5581, 5582, 5583, and in no way will affect the disposition of any benefit which may become payable under the Retirement or Group Life Insurance Acts applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect until (1) expressly changed or revoked by me in writing, (2) I transfer to another agency, or (3) I am reemployed by the same or another department or agency of the Government.

INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES:

Type or print first name, middle initial, and last name of each beneficiary	Type or print address (including ZIP Code) of each beneficiary	Relationship	Share to be paid to each beneficiary

I hereby direct, unless otherwise indicated above, that, if more than one beneficiary is named, the share of any deceased beneficiary who may predecease me shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. I understand that this Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby specifically reserve the right to cancel or change any designation of beneficiary, at any time, in the manner and form prescribed by the Comptroller General of the United States, and without knowledge or consent of the beneficiary.

(Date of execution--month, day, year) (Signature of employee)

WITNESS TO SIGNATURE:

(Signature of Witness) (Number and street) (City, State, and ZIP Code)

(Signature of Witness) (Number and street) (City, State, and ZIP Code)

PRINT OR TYPE NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYEE

THIS SPACE RESERVED FOR RECEIVING DATA OF EMPLOYING AGENCY

(Indicate date and by whom received)

DELIVER BOTH COPIES TO THE PROPER OFFICER OF YOUR AGENCY--DUPLICATE WILL BE NOTED AND RETURNED

Print pages 2 and 3 back-to-back.

Retrieve Data

Reset Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTIFICATION OF U.S. SAVINGS BOND ACTION, SERIES EE

The furnishing of your Social Security Number is required by the regulations governing U.S. Savings Bonds. CFR 353. The Social Security Numbers are used to maintain ownership records of the bonds. Other information requested by this form is also required under the above regulations to reestablish the rights, authority and/or entitlement of the signers. Failure to furnish any of the required information may prevent completion of the transaction.

Agency/Organization/Office _____

Employee's Social Security No. _____ Work Telephone Number _____

☑ New Enrollment	☐ Total Cancellation	☐ Changes	INCREASE ALLOTMENT

Employee Name *(First)* *(Initial)* *(Last)*

Refund? *(check one if 'Changes' checked)*
☐ Refund Balance ☐ Do Not Refund Balance

Amount To Be Allotted *Min $3.75* Each Pay Period _____

Effective Date:

☐ No Change to Existing Deduction Amount

1. Owner's Name to Appear on Bond *(First)* *(Initial)* *(Last)*

Owners Social Sec. No.

Action: ☐ Modify ☐ Add ☐ Delete

Mailing Address *(Number and Street)*

(City or Town) *(State)* *(ZIP Code)*

Bond Denomination
☐ $100 ☐ $200 ☐ $500 ☐ $1000

(Check One) *(First)* *(Initial)* *(Last)*
☐ Co-Owner ☐ Beneficiary

Social Sec. No.

2. Owner's Name to Appear on Bond *(First)* *(Initial)* *(Last)*

Owners Social Sec. No.

Action: ☐ Modify ☐ Add ☐ Delete

Mailing Address *(Number and Street)*

(City or Town) *(State)* *(ZIP Code)*

Bond Denomination
☐ $100 ☐ $200 ☐ $500 ☐ $1000

(Check One) *(First)* *(Initial)* *(Last)*
☐ Co-Owner ☐ Beneficiary

Social Sec. No.

3. Owner's Name to Appear on Bond *(First)* *(Initial)* *(Last)*

Owners Social Sec. No.

Action: ☐ Modify ☐ Add ☐ Delete

Mailing Address *(Number and Street)*

(City or Town) *(State)* *(ZIP Code)*

Bond Denomination
☐ $100 ☐ $200 ☐ $500 ☐ $1000

(Check One) *(First)* *(Initial)* *(Last)*
☐ Co-Owner ☐ Beneficiary

Social Sec. No.

4. Owner's Name to Appear on Bond *(First)* *(Initial)* *(Last)*

Owners Social Sec. No.

Action: ☐ Modify ☐ Add ☐ Delete

Mailing Address *(Number and Street)*

(City or Town) *(State)* *(ZIP Code)*

Bond Denomination
☐ $100 ☐ $200 ☐ $500 ☐ $1000

(Check One) *(First)* *(Initial)* *(Last)*
☐ Co-Owner ☐ Beneficiary

Social Sec. No.

I hereby authorize the following allotment from my pay with the understanding that the U.S. Savings Bond will be issued as requested. This authorization is to remain in effect until cancellation by me in writing or termination of my Federal employment.

Standard Form HHS 357
Revised March 1995
EF
Created by Electronic Document Services/USDHHS: (301)

_____ Employee's Signature

_____ Date

(FORWARD THE COMPLETED FORM TO YOUR SERVICING PERSONNEL OFFICE)

Save Data Print Email Form Next Page